Eric Holcomb, Governor
State of Indiana

Office of Medicaid Policy and Planning
, 402 W. WASHINGTON STREET, ROOM W374, MS 07
INDIANAPOLIS, IN 46204-2739

Medicaid Advisory Committee Minutes

May 13, 2021
Virtual meeting via Zoom

Members Present
Mr. Grant Achenbach, Dr. Leila Alter, Ms. Tabitha Arnett, Rep. Brad Barrett, Ms. Lacey Berkshire, Senator Jean Breaux, Mr. Matthew Brooks (Co-Chair), Senator Liz Brown, Rep. Chris Campbell, Rep. Ed Clere, Ms. Terry Cole, Ms. Elizabeth Eichhorn, Dr. Heather Fretwell, Ms. Rachel Halleck, Mr. Herb Hunter, Rep. Mike Karickhoff, Mr. Rodney King, Mr. Jason Kolkmeier, Ms. Barbara McNutt, Mr. Gary Miller, Ms. Audrea Racine, Mr. Evan Reinhardt, Mr. Mark Scherer, Rep. Robin Skackleford, Katy Stafford-Cunningham, Dr. Jennifer Sullivan, and Ms. Allison Taylor (Co-Chair).

I. Call to Order/Opening Comments

Medicaid Director and Co-chair Allison Taylor called the meeting to order at 10:03 a.m. and welcomed members and guests. Co-chair Taylor asked all MAC members to register their attendance and provided brief instructions about navigating the virtual platforms used today, Zoom for MAC members and presenters and YouTube for members of the public.

II. Approval of February 2021 Minutes

Co-Chair Brooks invited approval of the February 2020 meeting minutes. Mr. Evan Reinhart moved to approve. Mr. Rodney King seconded. The minutes were approved with no changes.

III. MAC Updates

Co-Chair Taylor invited MAC members to the July 29, 2021 special meeting for the annual review of waiver programs including enrollment and operations updates for HIP, SMI and SUD. The July meeting will not include an update on the 1135 waiver and no other business will be conducted. The next regular MAC meeting is scheduled for August 26, 2021 and the final meeting of the year is scheduled for November 16, 2021. The formats for these meetings are to be determined.

IV. Rules

Co-chair Brooks introduced Ms. Madison Hartman, Staff Attorney for FSSA, to present updates on LSA 19-602 (Article 2 Rule), LSA 21-32 (HIP Bridge Rule) and LSA 21-162 (3% Rate Reduction 2023 Rule).

LSA 19-602 amends 405 IAC 2 to amend its current rules to impacting Medicaid eligibility. The amendment adds criteria for post-eligibility treatment of income for members receiving home- and community-based service waivers. It creates eligibility criteria for End Stage Renal Disease services for members that are not otherwise eligible under the Medicaid state plan.

This rule implements new Medicaid financial eligibility requirements under Modified Adjusted Gross Income standards. Updates the real property resource criteria for purposes of determining eligibility and updates the rule to conform to the most current supplemental security income (SSI) policies. It amends the rule to conform to state law at IC 12-15-3-8 regarding college savings accounts and clarifies policy regarding burial spaces and funeral expenses. This rule establishes a Medicaid eligibility category for former foster care children and removes the expiration date of 405 IAC 2-8-1.1. Finally, this rule updates definitions and terminology and removes outdated references and amends the presumptive eligibility criteria and process. The public hearing was held on August 13, 2020 and received one oral comment and 6 written comments. OMPP with the help of OGC reviewed the comments to determine whether any changes should be made to the proposed rule as a result. OMPP made changes in accordance with the comments. OGC is currently assembling the blue binder for the rule. After assembling the blue binder, the rule will be submitted to the FSSA Secretary and the Office of the Attorney General for approval and adoption. Ms. Hartman invited questions. There were none.

Ms. Hartman then provided an update on LSA 21-32 (HIP Bridge Rule). The proposed rule amends 405 IAC 10-13 adds HIP Workforce Bridge Account guidelines. The HIP Workforce Bridge Account provides $1,000 for eligible members to use for qualified health care expenses during the 12-month period following disenrollment from HIP. This account is available to individuals who are no longer eligible for HIP due to an increase in income and who have completed enrollment in commercial insurance or will need to complete enrollment in commercial insurance to have continued coverage. The Notice of Intent to Adopt a Rule was published in the Indiana Register on February 3, 2021. The fiscal statements were submitted to the State Budget Agency (SBA) and the Indiana Economic Development Corporation (IEDC) for review and approval on February 17, 2021. The Notice of Public Hearing was published in the Indiana Register on March 24, 2021. The Public Hearing was held on April 19, 2021 and OMPP received 2 positive comments on the rule. OMPP responded to these positive comments and OGC has assembled the blue binder for the rule. The rule was submitted and adopted by the FSSA Secretary on May 12, 2021 and was submitted to the Office of the Attorney General on May 12, 2021 for approval and adoption. Ms. Hartman invited questions. There were none.

Ms. Harman then presented LSA 21-162 (3% Rate Reduction 2023). The proposed rule amends 405 IAC 1-8-3 to extend through June 30, 2023 the three percent (3%) rate reduction for covered outpatient hospital services that is currently set to expire on June 30, 2021. It amends 405 IAC 1-10.5-6 to extend through June 30, 2023 the three percent (3%) rate reduction for covered inpatient hospital services that is currently set to expire on June 30, 2021. Effective 30 days after filing with the Publisher. Statutory authority: IC 12-15-1-10; IC 12-15-21-1; IC 12-15-21-2; IC 12-15-21-3. The notice of intent was published on April 28, 2021 and the next step is submission of documents for approval by SBA. Ms. Hartman invited questions.

Senator Breaux asked where the rules could be found online. Ms. Hartman responded that all rules can be found at this link: http://iac.iga.in.gov/iac/irtoc.htm.

Terry Cole asked whether the 3% rule can still be changed. Tabitha Arnett asked whether there will be a notice of public hearing. Ms. Hartman responded that the notice of public hearing would be coming soon after the proposed rule documents are filed with the correct agencies.

V. FSSA Updates

Co-Chair Taylor briefly reviewed OMPP's strategic priorities, provided an update about extending postpartum coverage for Hoosier mothers for twelve months after delivery, and outlined the topics for today's MAC. She then introduced Ms. Meredith Edwards, Quality and Outcomes Section Director, to discuss the Medicaid Quality Strategy Plan.

1. Medicaid Quality Strategy Plan—Meredith Edwards, Quality and Outcomes Section Director

Ms. Edwards introduced herself and presented information about Indiana's Medicaid Quality Strategy Plan (QSP), a federally required plan for assessing and improving the quality of health care services furnished by managed care.

The plan is available at https://www.in.gov/fssa/ompp/quality-and-outcomes-reporting/

In 2021, the QSP focused on the following initiatives that align with State and FSSA goals: infant mortality reduction, smoking cessation, primary care and preventive services, dental care, health equity, substance use disorder treatment and managed care entity alignment. Hoosier Healthwise, Healthy Indiana Plan and Hoosier Care Connect had specific measures outlined on presentation slides 9-11.

Ms. Edwards next discussed slides 12-18 outlining HEDIS measures and trends through 2019. (2020 data will not be available until July-August 2021.) HEDIS is a comprehensive set of standardized, nationally benchmarked performance measures created by the National Committee on Quality Assurance. A random statistically significant sampling of members is taken to determine the rates. Highlights from the slides include:

- Hoosier Healthwise: 50-62% of members (age 2-20) had an annual dental visit
- Hoosier Healthwise: 64% of members received a lead screening by age 2
- Hoosier Healthwise: 60-80% of children age 0-15 months received more than 6 well child visits
- Healthy Indiana Plan: 75-95% of adults received an annual preventive care visit
- Healthy Indiana Plan: 80-95% of pregnant members received a prenatal visit in the first trimester or within 42 days of enrollment
- Hoosier Care Connect: 85% of adults received an annual preventive care visit
- Hoosier Care Connect: 60% of adults received a follow-up care visit within 30 days after hospitalization for mental illness

The QSP was released for public comment on April 28 and the public comment period closes on May 28, 2021. Comments can be sent to Sue Beecher, Program Evaluation Manager, at Susan.Beecher@fssa.in.gov.

Ms. Edwards invited questions. There were none.

2. LTSS Update – Dr. Jennifer Sullivan, FSSA Secretary, and Dr. Daniel Rusyniak, FSSA Chief Medical Officer

Co-Chair Taylor introduced Dr. Jennifer Sullivan, Dr. Daniel Rusyniak and Sarah Renner, Director of FSSA's Division of Aging.

The LTSS (long term services and support) project is an intensive 4-year initiative involving multiple FSSA divisions, other state agencies, and external stakeholder groups with the vision of creating the infrastructure to allow as many Hoosiers to age in their homes, if they so choose, while maintaining long-term care facilities for those who have specific needs and concerns.

The project initially began in 2018 when we examined the federal Home and Community Based Services (HCBS) Settings Rule and what it meant to be "at home" and "in an institution" and how to move members back and forth between those settings. Additionally, we recognized the tension between the regulatory space and the payor space and also what consumers want. Through the LTSS project, we are addressing these areas to develop a long-term strategy we can all be proud of.

In 2019, FSSA convened stakeholders to discuss LTSS system improvements with a focus on aging at home. When Hoosiers start the aging journey, they need to have a menu of options from which to choose, so they receive the right care at the right time in the right place and have the flexibility to transition between settings when necessary within a 48 hour period of time [slide 4].

Based on stakeholder feedback, the common issues and concerns were: (1) the length of time to access services, particularly determination of financial eligibility, (2) long-term financial viability of current service delivery with a growing population, (3) provider capacity to deliver services, and (4) consumer and provider lack of knowledge regarding options or how to prepare. We do not want delays in accessing care, confusion or exclusion of consumers, unsustainability, or lack of capacity to meet consumer demand [slide 5].

From 2010 to 2030 the proportion of Hoosiers over age 65 will grow from 13% to 20% and Indiana's disjointed LTSS system must be reformed to meet growing demand and to ensure consumer choice, quality care and long-term financial sustainability [slide 6].

To achieve the project's two-fold objective—75% of new LTSS members will live and receive services in a home- and community-based setting and 50% of LTSS spend will be on home- and community-based services—we are driven by four key results: (1) ensure Hoosiers have

access to home- and community-based services within 72 hours, (2) move LTSS into a managed care model, (3) link provider payments to member outcomes (value-based purchasing), and (4) create an integrated LTSS data system linking individuals, providers, facilities and the state [slide 7].

Partners across state government, FSSA, and stakeholders have been involved in and will continue to be involved in the project. Since January 2021, FSSA has conducted numerous stakeholder engagement sessions to gather input regarding the vision for managed LTSS including: stakeholder workgroups (10 meetings to date) composed of LTSS industry associations and organizations serving older adults to discuss mLTSS design and finance considerations; lunch and learn educational sessions (9 meetings to date) by FSSA and guest speakers representing stakeholder organizations and community partners; and focus group listening sessions (7 meetings to date) diving into detailed topics identified by subsets of stakeholders as areas of particular interest [slides 8-9].

The most important engagement will occur after mLTSS "goes live" and FSSA is launching additional, multi-year efforts to gather consumer, caregiver and provider feedback.

Dr. Rusyniak reviewed the progress made to date on the four key results (KR) [slides 12-17].

- KR1-Expedited Eligibility – Indiana has been piloting expedited eligibility for LTSS under federal public health emergency authorities since the fourth quarter of 2020 and to date nearly 1,200 applications have been approved. Next steps include evaluating the pilot and developing long-term solutions using lessons learned. Special thanks to Natalie Angel (FSSA OMPP) and Jesse Wyatt (FSSA Division of Aging) for their work.

- KR2-Managed LTSS Design-In January 2021, a stakeholder workgroup was established to discuss mLTSS design options and potential Request for Information (RFI) questions and to date 6 workgroup meetings and 7 focus groups have been convened. The group also reviewed specific mLTSS programs in other states. We are in the middle of the design process and there is still much intense work to be done over the next several months. Next steps include continuing conversations with stakeholders and releasing an RFI in early summer 2021. The current plan is to release the Request for Proposal (RFP) in early 2022 and implement mLTSS in early 2024. Special thanks to Natalie Angel (FSSA OMPP) and Sarah Renner and Jesse Wyatt (FSSA Division of Aging) for their work.

  Additionally, Kathy Leonard (FSSA OMPP) is leading the efforts to strategically transition current fee-for-service LTSS reimbursement structures to drive quality, alignment, transparency, person-centeredness, and sustainability, and to provide compatibility with managed care. Stakeholder meetings began in February 2021 and, with the support of Milliman, we developed a plan for a strategic review and recommendations for nursing facility base rates, nursing facility upper payment limit (UPL), quality and value-based purchasing (VBP), home health and HCBS rates, and

mLTSS capitation rates. Next steps include convening a series of stakeholder meetings to discuss and begin developing recommendations for each rate topic area.

- KR3-Value-Based Purchasing-Elizabeth Peyton (FSSA Division of Aging) and Tim McFarlane (FSSA Data and Analytics) are leading the efforts to link provider payments to improved health and wellness (VBP). To date, this effort has begun establishing a decision-making framework on an HCBS VBP performance measure set, conducted a review of how other states are measuring HCBS for VBP and the recent CMS request for information soliciting input from states and stakeholders on the same topic, and developed a caregiver survey in partnership with WISE Indiana. Supporting family caregivers is a very important component. Next steps include administering the caregiver survey and the federal HCBS Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey, reviewing existing measure sets from programs and purposes similar to Indiana's goals and audience, and assessing implementation and feasibility of measure among HCBS providers for long-term sustainability.

- KR4-Integrated Data Systems-Conner Norwood and Tim McFarlane (FSSA Data and Analytics) are leading the effort to create an integrated cloud environment to capture and use LTSS-related data from multiple sources now, during and after the LTSS transition. Next steps include developing a plan to monitor the LTSS program before, during and after implementation.

Dr. Sullivan concluded by saying FSSA is very excited about the work ahead and thanked the General Assembly and legislators on the MAC for their partnership and collaboration during the 2021 session.

Upcoming LTSS activities include: conducting a comprehensive evaluation of the expedited eligibility pilot, continuing stakeholder engagement sessions and releasing the RFI, hosting small group discussions regarding Medicaid finance issues, piloting the caregiver and HCBS CAHPS surveys, prioritizing new data sources for inclusion in the LTSS data environment, launching an LTSS webpage, engaging with consumers and caregivers, and conducting an environmental scan and gap analysis in the workforce. Questions and comments can be sent to the LTSS inbox at backhome.indiana@fssa.in.gov.

Co-chair Brooks thanked Dr. Sullivan and Dr. Rusyniak and invited questions.

Questions asked in virtual chat room

Q: Tabitha Arnett – Is the VBP purchasing or reimbursement modeled after another state or similar program? Will member outcomes also have elements of member compliance with provider direction?
A: Dr. Rusyniak – Indiana won't have one that looks like another state's due to our priorities and needs, although TN does have a program right now. We are focusing on outcomes and

the VBP program comes after determining outcome data points and baseline. There will be a lot of discussions over the next few months. By the time we have an RFP, we'll have the outcomes available for review.
A: Dr. Sullivan – I concur with everything Dan said. Reform is important because our nursing facility partners and their critical access hospitals that participate in the current UPL program rely on that source of income and transformation in that space must be thoughtful because we do not want to cause harm. We want to do this right and the VBP UPL process will be lengthier than the others.

Q: Senator Breaux – Is there activity at the federal level regarding UPL that will impact what we do at the state level?
A: Dr. Sullivan – The conversations that we had a year or so ago have ended and there is no activity at the federal level in the current administration, but it might come in the future. The work that we are doing right now is important in preparation for any future conversations.

Q: Elizabeth Eichhorn – What concerns about managed care have been raised during the focus groups? What is being done to address those concerns? Would they be resolved before implementation?
A: Dr. Sullivan – Documents will be available on the LTSS website and the four-year timeline allows us to work through issues prior to go live. An example is the credentialing process which we have put on pause to work out how different industries will adjust to this. We also want to ensure there is not administrative burden that overwhelms an industry that is not used to it. How does the back office change in order to intersect with managed care in order to ensure utilization management is done thoughtfully and is streamlined across any organizations if we have multiple managed care entities that are partnering with us that they have the same guidelines and rules on how to work with the industry?

Q: Rep. Ed Clere – I would like to go back to the slide when you talked about the transition from hospital to HCBS within 72 hours, is that right?
A: Dr. Sullivan – Yes.
Q: Rep. Ed Clere - Could you provide more details about how that would work in practical terms when a hospital is ready to discharge someone before the 72 hours? How do we bridge that transition?
A: Dr. Sullivan – With the expedited eligibility pilot that we're doing under our Appendix K authority, we started with people who are already good at expedited eligibility, including our Area Agencies on Aging. Essentially, those applying for services provide us with a couple of items, and if it looks like they are eligible they are approved for services and we go in on the back end and do all of the other processing, rather than doing it during initial application. The pilot has also expanded what providers can do presumptive eligibility. For your specific scenario, we added our first hospital to do this work and they are doing a great job. With case management embedded in the hospital, if someone wants to go home and we think they can go home, we will set them up with HCBS and do the expedited eligibility process. This really levels the playing field to avoid sending someone to a facility when they can go home. Right now it may be a day longer to set up, but it is not six weeks longer. And

it does not turn a short stay in a facility into a long stay. The goal of having all of the new providers in the eligibility determination space is we take the experience of our pilot hospital and expand the opportunity out for everyone for our future state.
Q: Rep. Ed Clere – You are talking about the possibility of a transitional stay in a nursing home?
A: Dr. Sullivan – We would actually be able to skip that. The idea is that you would go from hospital, get your presumptive eligibility for your LTSS services for home, and your provider meets you at your home.
Q: Rep. Ed Clere – What if a member is discharging from a hospital on a Friday afternoon and home health agency cannot start services or even be contacted until Monday, how do we bridge the person through the weekend? Has there been any discussion about providing an interim hospital reimbursement to keep the person in place until services are available rather than forcing the individual's or family's hand to make a decision just because of unfortunate timing?
A: Dr. Sullivan – I will take these questions back for discussion.

Q: Senator Liz Brown – How are we going to address the workforce issue? Do we have certified, credentialed and capable home health care aides?
A: Dr. Sullivan – We have a dedicated workstream to address workforce. Workforce capacity is a pervasive issue across multiple divisions and we have to think about how we bring people into these services. "Rebalancing" involves the money we spend on LTSS and shifting that toward paying for HCBS. So we have to recruit and retain people in this space. I think a lot of what we are going to do with our American Rescue Plan Act funding is dedicate it to workforce growth for HCBS because we know we are going to need it in the next couple of years as people start accessing those services. We cannot do any of this without building workforce initiatives. For example, in our Early Childhood Education division, we are offering scholarships for people to come into early learning/childcare. That initiative has resulted in 1,500 new early childhood teachers being added to the workforce recently. Offering incentives now is important so we have capacity in the future.

Co-Chair Brooks again thanked Dr. Sullivan and Dr. Rusyniak.

3. *Division of Mental Health update – Jay Chaudhary, Director, Rachel Halleck, Deputy Director and Chief of Staff, and Dr. Christopher W. Drapeau, Indiana Suicide Prevention Director*

Co-Chair Taylor introduced Jay Chaudhary, Director of FSSA's Division of Mental Health and Addiction (DMHA) and described suicide prevention as being one of the most complex issues to address because each individual in crisis has a unique set of circumstances and prevention involves the intersection of many systems including law enforcement, healthcare, behavioral health, and criminal justice. The state has an obligation to build out an infrastructure and work with communities. Mr. Chaudhary introduced Dr. Christopher W. Drapeau, Indiana Suicide Prevention Director, who presented information about Indiana's proposed 988 infrastructure which will transform crisis response.

The highest rates of suicide in our country were reported during the Great Depression era. In 2017 and 2018, youth suicide (15-24 year olds) was the highest ever reported in our country. Youth suicide has increased through the late 1970s and remained stabled or declined until these recent increases. The last decade (2010s) was the second highest decade on record.

In a recent CDC study, Indiana was 10th highest in the percent of increase in suicide ideation and death rates among persons aged 10-24 years. Persons aged 13-24 represent the greatest number of callers to Indiana's Suicide Hotline. During the pandemic, there have been significant increases in the number of calls to the hotline.

The National Suicide Hotline Authorization Act was signed by former President Trump last summer. This will reduce the 10-digit national suicide prevention hotline number to 3-digits (988) by July 16, 2022. In January 2021, DMHA received a Vibrant 9-8-8 State Planning Grant for the period of February 1, 2021-September 30, 2021, to develop clear roadmaps for addressing key coordination, capacity, funding and communication strategies that are foundational to launching 988 on or before July 16, 2022 and develop a plan for the long-term improvement of in-state answer rates for 988 calls.

The vision for 988 is to provide quick, competent, and nation-leading crisis response for every Indiana resident. We want Indiana to be the best of the best. 988's mission is creating a sustainable infrastructure that will fully coordinate crisis care for mental health, substance use, and suicidal crises (through implementing the SAMHSA-adopted Crisis Now Model). Indiana is building a Level 5 Crisis Center. The Crisis Now Model is a system that serves anyone, anytime and anywhere. It will provide statewide 24/7 coverage for 988 calls, text, and chat (someone to talk to). It will involve centrally deployed, 24/7 mobile crisis (someone to respond). It will provide a place to go for those needing short-term sub-acute residential crisis stabilization programs. This model will build centers that can dispatch mobile crisis teams, know the availability of crisis beds anywhere in the state, and provide follow-up after discharge to keep patients connected with care. The model saves people by providing a more efficient response and follow-up and also saves money.

We are working to ensure the 911 and 988 systems are interoperable. The key elements of a Level 5 call center are: status disposition for intensive referrals, 24/7 outpatient scheduling, shared bed inventory tracking, high-tech, GPS-enabled mobile crisis dispatch, and real-time performance outcome dashboards.

The 988 state planning grant expects: (1) 24/7 coverage statewide, (2) the capacity to meet call volume growth projections, (3) strategies for identifying and supporting funding streams to boost the financial stability of 988 centers, (4) DMHA must account for the operational, clinical, and performance standards for all 988 centers, and (5) DMHA shall ensure 988

centers have systems in place to maintain local resource and referral listings, as well as assure linkages to local community crisis services.

The proposed organizational design is comprised of (1) the statewide 988 Board to discuss issues and provides oversight for the entire 988 system, (2) the 988 command center which coordinates the continuum of care, and (3) the 988 satellite centers which answer calls, texts and chats. This hierarchical design yields consistency across the operations for the consumer and allows the entire system to quickly and collectively adapt to changes in service delivery. The pros and cons of this design are described on slides 14-16.

Based on feedback provided by our 911 partners, 988 should begin building the infrastructure centrally and slowly expand as resources become available and build centers that have the flexibility to expand physically and technologically. This centralized approach is less stressful to manage on the personnel side and should be more cost effective.

Questions/Comments in virtual chat room

Q: Rodney King – Is there data available on callers whose issues were not resolved and they committed suicide?
A**:** Dr. Drapeau – No, this information is not collected. There was a study for the Veteran's Crisis Line and it was significantly elevated. But I am unsure what this looks like for Indiana. A very small portion of calls require law enforcement or EMS response due to imminent suicide risk.
Q: Rodney King – What would mobile crisis teams do?
A: Dr. Drapeau – Different models exist. Community mental health centers are standing up mobile crisis centers across the state. So it may be a mixture of CMHCs, trained individuals, law enforcement, social workers, and peer advocates. EMTs have been used but are not a prominent component. The recording for the Tuesday, May 11, meeting contains an in-depth discussion about the model: https://mhai-net.zoom.us/rec/play/NXO-AgdeUBp6dqM0U_kxooPNRfx2YAfTXn3FsavN_eJnXxLC-aLlzqNp8nziAmejQCOupjDL4ftOdT19.s1XeBIhHxpqRRbvU
A: Co-Chair Brooks – We are working with FSSA to try to create consistency in the interpretation of the statute as it relates to the 988 business model. There is a lot of great opportunity here and we are excited about crisis response in the future.

Q: Representative Ed Clere – Did you touch on HEA1468?
A: Dr. Drapeau – I just briefly mentioned it.
A: Representative Ed Clere – This is Representative Davison's bill. After June 30, 2022, would require 988 to student ID cards. There is an opportunity for ongoing conversation about that because in conference committee, we added a couple of other hotline numbers to that and there was some concern about it becoming cumbersome and confusion about what the 988 number would include. Some legislators believed it would be a comprehensive crisis number

inclusive of suicide prevention and other services as well. There will be opportunity to provide additional education around 988 services moving forward into the next legislative session and we have to get the language right. Since this takes effect in 2022, we need to work with school leaders for the production of the ID. I just do not want to lose any of the momentum going into the 2022 session cards and am happy to work with you on any communication and education to preserve and refine the provision that is in statute.
A: Dr. Drapeau – The focus of 988 is on mental health, substance use, and suicidal crises. Those are the three main areas.
Q: Representative Ed Clere - We added sexual assault, dating violence, I believe, and human trafficking is also in there. So there were concerns about what was covered and what was not covered and making sure that everything that needs to be covered is and there is no duplication. I just want to make sure we get it right if there is a need for refinement and hopefully resolve some of the heartburn that arose at the end of session. Once implemented, I believe this will save lives.

Co-Chair Brooks thanked Representative Clere for his efforts on HEA1468.

VI. Public Comments

Co-Chair Brooks invited questions and comments from the public.

Questions/Comments in virtual chat room

Q: Natasha Eccles – I agree the 3-digit number would likely increase consumer use. The EMTs would not be properly certified to provide mental health treatment. If the caller were injured, yes. But I would not send a mental health professional without law enforcement.
A: Co-chair Brooks – Only 8% of 911 calls are related to mental health and addiction. However, 82% of incarcerated individuals have a mental health or addiction disorder. So there is an opportunity for proper training for individuals who respond to crises. The legislation created a broad framework for 988. The administrative rule process and collaborative process in putting this together is helping this to happen. Issues about liability, staffing, reimbursement rates and scope of practice for various providers are all being considered.

VII. Closing Comments

Co-chair Brooks invited final questions from MAC members.

Co-Chair Taylor indicated the SUD/SMI Workgroup Update on today's agenda would be presented during the August 26, 2021 meeting.

Co-Chair Taylor reminded MAC members that changes were made to telehealth when Senate Bill 3 was signed into law and thanked legislators for helping to expand telehealth. The statute supplements healthcare to reduce disparities and barriers, replaced outdated terms and language, removed location requirements, expanded the list of practitioners who can provide telehealth, and allows for audio-only telehealth. Licensed providers will be able to provide services under telehealth. In the behavioral services/mental health space those licensed under IC 25-23.6 but does not include students working toward licensure or unlicensed professionals. Indiana Medicaid will follow the Governor's Executive Order until the end of the public health emergency. At the end of the PHE, Indiana will transition into Senate Enrolled Act 3 and will communicate as much as possible through the IHCP bulletins to provide formal notice 30 days prior to policy changes and as updates are made.

Co-Chair Brooks thanked FSSA's staff and asked for final comments before adjournment.

With no further business to conduct, the meeting adjourned at 12:00 p.m.